I

104TH CONGRESS
1ST SESSION

H. R. 2408

To provide for enhanced penalties for health care fraud, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 27, 1995

Mr. COBURN introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, the Judiciary, and Government Reform and Oversight, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To provide for enhanced penalties for health care fraud, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Care Anti-Fraud Act of 1995''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—FRAUD AND ABUSE CONTROL PROGRAM

SEC. 101. CREATION OF NATIONAL HEALTH CARE ANTI-FRAUD TASK FORCE.

(a) PURPOSE.—The Attorney General in consultation with the Secretary of the Department of Health and Human Services shall establish a national health care fraud task force to coordinate Federal law enforcement agencies to control fraud and abuse in the delivery of health care in the United States. This task force, through its regional offices, shall have the power to pursue both civil and/or criminal actions against any individual organization, or other entity whose acts knowingly and willfully amount to health care fraud or knowingly and willfully amount to fraud and abuse in the delivery of health care in the United States.

(b) IN GENERAL.—Consistent with section 101 of subtitle A, not later than one hundred twenty days after enactment, the Attorney General shall establish a health care fraud task force—

(1) to target, investigate, and prosecute individuals who organize, direct, finance, or are otherwise knowingly engaged in health care fraud;

(2) to work fully and effectively with State and local law enforcement agencies;

(3) to promote a coordinated health care fraud enforcement effort and to encourage maximum co-operation among all Federal agencies; and

(4) to make full use of financial investigative techniques, including tax law enforcement and, in order identify and convict individuals and sanction entities that engage in health care fraud.

(c) PARTICIPANTS.—The Federal agencies that shall participate in the health care fraud task force are—

(1) the Department of Justice (including the Federal Bureau of Investigation);

(2) the Department of Health and Human Services (including the Office of the Inspector General);

(3) the Department of Defense (CHAMPUS);

(4) the Veteran's Administration:

(5) the Railroad Retirement Board;

(6) the United States Postal Inspection Service; and

(7) the Internal Revenue Service.

(d) The President shall designate one of the members as chair. The chair serves a term concurrent with that

of the President. The chair shall serve as the chief executive officer of the task force.

SEC. 102. EMPLOYEES OF THE TASK FORCE.

(a) Effective January 1, 1996, the following employees of the Government of the United States shall be assigned to the task force but shall remain as employees of their former Government employer for purposes of salary, compensation, benefits and all related matters:

(1) Employees of the Department of Health and Human Services whose primary duties related to health care fraud.

(2) Employees of the Department of Justice whose primary duties relate to health care fraud to include employees of the Federal Bureau of Investigation and the Office for United States Attorneys; and

(3) Any other employee of the Federal Government selected by the Commission for assignment to the task force.

(b) The number of employees assigned to the task force pursuant to subsection (a) shall be sufficient to allow the task force to perform its objectives; provided, however, that the total number of individuals does not exceed fifty (50).

(c) OBJECTIVES.—The objectives of the task force shall be—

(1) to target, investigate, and prosecute individuals who organize, direct, finance, or are otherwise engaged in health care fraud;

(2) to promote a coordinated health care fraud enforcement effort, and to encourage maximum cooperation among all Federal agencies; and

(3) to work fully and effectively with State and local law enforcement agencies.

SEC. 103. FRAUD AND ABUSE CONTROL PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—Not later than January 1, 1996, the Secretary of Health and Human Services (in this title referred to as the ''Secretary''), acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall, after consultation with the task force, establish a program—

(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to the delivery of and payment for health care in the United States;

(B) to conduct investigations, audits, evaluations, and inspections, including undercover

operations, relating to ''fraud and abuse in'' the delivery of and payment for health care in the United States;

(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B of the Social Security Act (42 U.S.C. 1320a–7, 1320a–7a, and 1320a–7b) and other statutes applicable to health care fraud and abuse; and

(D) to provide for the modification and establishment of safe harbors, and to issue advisory opinions and special fraud alerts pursuant to section 105.

(2) COORDINATION WITH HEALTH PLANS.—In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data, with representatives of health plans.

(3) REGULATIONS.—

(A) IN GENERAL.—The Secretary and the Attorney General shall by regulation establish standards to carry out the program under paragraph (1).

(B) INFORMATION STANDARDS.—

(i) IN GENERAL.—Such regulations shall include standards relating to the fur-

nishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans under paragraph (2)).

(ii) CONFIDENTIALITY.—Such regulations shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall apply—

(I) to a person providing information or communications to the Commission, the Secretary or the Attorney General in conjunction with their performance of duties under this Act; or

(II) to health plans sharing information in good faith and without mal-

ice with any other health plan with respect to matters relating to health care fraud detection, investigation and prosecution.

(4) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human services is authorized to exercise such authority described in paragraphs (4) and (5) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.) (relating to subpoenas and administration of oaths) with respect to the activities under the fraud and abuse control program established under this subsection to the same extent as the Inspector General may exercise such authorities to perform the functions assigned by such Act.

(5) AUTHORITY OF INSPECTOR GENERAL.—Nothing in this Act shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978 (5 U.S.C. App.).

(b) HEALTH PLAN DEFINED.—For purposes of this section, the term ''health plan'' means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

(1) a policy of health insurance;

(2) a contract of a service benefit organization;

(3) a membership agreement with a health maintenance organization or other prepaid health plan; and

(4) an employee welfare benefit plan or a multiple employer welfare plan (as such terms are defined in section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002).

SEC. 104. COURT-IMPOSED OBLIGATIONS UPON HEALTH CARE FRAUD AND ABUSE CONVICTIONS.

(a) IDENTIFICATION OF COMMUNITY SERVICE OPPORTUNITIES.—Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:

''(g) The Secretary may—

''(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section, and

''(2) make information concerning such opportunities available to Federal and State law enforcement officers and State and local health care officials.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1996.

SEC. 105. HEALTH CARE FRAUD AND ABUSE GUIDANCE.

(a) SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

(1) IN GENERAL.—

(A) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than January 1, 1996, and not less than annually thereafter, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

(ii) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)) and shall not serve as the basis for an exclusion under section

1128(b)(7) of such Act (42 U.S.C. 1320a–7(b)(7));

(iii) advisory opinions to be issued pursuant to subsection (b); and

(iv) special fraud alerts to be issued pursuant to subsection (c).

(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall by May of each year publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall within 60 days after the close of the comment period issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

(C) REPORT.—The Inspector General of the Department of Health and Human Services (in this section referred to as the ''Inspector General'') shall, in an annual report to Con-

gress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

(2) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under paragraph (1)(B), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

(A) An increase or decrease in access to health care services.

(B) An increase or decrease in the quality of health care services.

(C) An increase or decrease in patient freedom of choice among health care providers.

(D) An increase or decrease in competition among health care providers.

(E) An increase or decrease in the cost to health care programs under the Social Security Act.

(F) An increase or decrease in the potential overutilization of health care services.

(G) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in health care programs under the Social Security Act.

(b) ADVISORY OPINIONS.—

(1) ADVISORY OPINIONS UNDER TITLE XI.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

''ADVISORY OPINIONS

''SEC. 1129. (a) ISSUANCE OF ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as provided in this section.

''(b) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

''(1) What constitutes prohibited remuneration within the meaning of section 1128B(b) of the Social Security Act.

''(2) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section

1128B(b)(3) of the Social Security Act for activities which do not result in prohibited remuneration.

''(3) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

''(4) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX within the meaning of section 1128B(b).

''(5) Whether an arrangement or proposed arrangement will result in a prohibited referral within the meaning of section 1877 of the Social Security Act.

''(6) Whether an arrangement, activity or proposed arrangement or proposed activity violates any other provision of this Act.

''(c) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

''(1) Whether the fair market value shall be, or was paid or received for any goods, services or property.

''(2) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

''(d) EFFECT OF ADVISORY OPINIONS.—

''(1) IN GENERAL.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion, so long as the party's actions or omissions do not deviate from the actions or omissions presented in the request for the advisory opinion.

''(2) The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, 1128B, 1877, of this Act.

''(e) FEE.—

''(1) IN GENERAL.—The Secretary shall require an individual or entity requesting an advisory opinion under this section to submit a fee.

''(2) AMOUNT.—The amount of the fee required under paragraph (1) shall be equal to the costs incurred by the Secretary in responding to the request.

''(f) REGULATIONS.—The Secretary within 90 days of the date of the enactment shall issue regulations estab-

lishing a system for the issuance of advisory opinions. Such regulations shall provide for—

''(1) the procedure to be followed by a party applying for an advisory opinion;

''(2) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

''(3) the interval in which the Secretary shall respond; and

''(4) the manner in which advisory opinions will be made available to the public.

''(g) INTERVAL FOR ISSUANCE OF ADVISORY OPINIONS.—Under no circumstances shall the interval in which the Secretary shall respond to a party requesting an advisory opinion exceed 30 days.''.

(2) ADVISORY OPINIONS RELATING TO PHYSICIAN OWNERSHIP AND REFERRAL.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended by the addition of the following new subsection:

''(i) ADVISORY OPINIONS.—

''(1) IN GENERAL.—The Secretary shall issue advisory opinions on whether an arrangement or proposed arrangement will result in a prohibited referral within the meaning of this section.

''(2) EFFECT OF ADVISORY OPINIONS.—

''(A) Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion, so long as the party's actions or omissions do not deviate from the actions or omissions presented in the request for the advisory opinion.

''(B) The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of this section.

''(3) FEE.—

''(A) IN GENERAL.—The Secretary shall require an individual or entity requesting an advisory opinion under this section to submit a fee.

''(B) AMOUNT.—The amount of the fee required under paragraph (1) shall be equal to the costs incurred by the Secretary in responding to the request.

''(3) REGULATIONS.—The Secretary within one hundred and twenty days of the date of enactment, shall issue regulations establishing a system for the issuance of advisory opinions. Such regulations shall provide for—

''(A) the procedure to be followed by a party applying for an advisory opinion;

''(B) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

''(C) the interval in which the Secretary shall respond; and

''(D) the manner in which advisory opinions will be made available to the public.

''(4) INTERVAL FOR ISSUANCE OF ADVISORY OPINIONS.—Under no circumstances shall the interval in which the Secretary shall respond to a party requesting an advisory opinion exceed thirty days.''.

(c) SPECIAL FRAUD ALERTS.—

(1) IN GENERAL.—

(A) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Inspector General for a notice which informs the public of practices which the Inspector General considers to be suspect or of particular concern under section 1128B(b) or section 1877 of the Social Security Act (42 U.S.C. 1320a–7b(b) or 42 U.S.C. 1395nn) (in this subsection referred to as a ''special fraud alert'').

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

(A) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in subsection (a)(2); and

(B) the volume and frequency of the conduct that would be identified in the special fraud alert.

TITLE II—REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE

SEC. 201. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) INDIVIDUAL CONVICTED OF FELONY RELATING TO HEALTH CARE FRAUD.—

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

''(3) FELONY CONVICTION RELATING TO HEALTH CARE FRAUD.—Any individual that has been convicted after the date of the enactment of the Health Care Anti-Fraud Act of 1995, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.''.

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 1128(b) of such Act (42 U.S.C. 1320a–7(b)) is amended to read as follows:

''(1) CONVICTION RELATING TO FRAUD.—

''(A) CONVICTION RELATING TO HEALTH CARE FRAUD.—Any individual or entity with respect to a misdemeanor, or entity with respect to a felony, that has been convicted after the date of the enactment of the Health Care Anti-Fraud Act of 1995, under Federal or State law, of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

''(i) in connection with the delivery of a health care item or service; or

''(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency;

''(B) CONVICTION RELATING TO FRAUD GENERALLY.—Any individual or entity that has been convicted after the date of enactment of the Health Care Anti-Fraud Act of 1995, under

Federal or State law, of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.''.

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted after the date of the enactment of the Health Care Anti-Fraud Act of 1995, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) of such Act (42 U.S.C. 1320a–7(b)(3)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

SEC. 202. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(c)(3) of the Social Security Act (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

''(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

''(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or

(b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

SEC. 203. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.

Section 1128(b) of the Social Security Act (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

''(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—Any individual who has a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer or managing employee (as defined in section 1126(b)) of, an entity—

''(A) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection; or

''(B) that has been excluded from participation under a program under title XVIII or under a State health care program, if the individual knew or had reason to know of the offense of the entity upon which the conviction or exclusion was based.''.

SEC. 204. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.

''(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) of the Social Security Act (42 U.S.C. 1320c–5(b)(1)) is amended by striking ''may prescribe)'' and inserting ''may prescribe, except that such period may not be less than 1 year)''.

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) of such Act (42 U.S.C. 1320c–5(b)(2)) is amended by striking ''shall remain'' and inserting ''shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain''.

(b) REPEAL OF ''UNWILLING OR UNABLE'' CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) of the Social Security Act (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking ''and determines'' and all that follows through ''such obligations,''; and

(2) by striking the third sentence.

SEC. 205. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) of the Social Security Act (42 U.S.C. 1395mm(i)(1)) is amended by striking ''the Secretary may terminate'' and all that follows and inserting ''in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or

''(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).''.

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

''(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

''(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

''(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

''(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.''.

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) of such Act (42 U.S.C. m(i)) is amended by adding at the end the following new paragraph:

''(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the organization fails to develop or implement such a plan;

''(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an entity has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to their attention;

''(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

(4) CONFORMING AMENDMENTS.—Section 1876(i)(6)(B) of such Act (42 U.S.C. mm(i)(6)(B)) is amended by striking the second sentence.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1996.

TITLE III—ADMINISTRATIVE AND MISCELLANEOUS PROVISIONS

SEC. 301. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.

(a) GENERAL PURPOSE.—Not later than January 1, 1996, the Secretary (in this title referred to as the ''Secretary'') shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c).

(b) REPORTING OF INFORMATION.—

(1) IN GENERAL.—Each Government agency and health plan shall report to the task force described in section 101 any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

(A) The name and TIN (as defined in section 7701(a)(41)) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner is affiliated or associated.

(C) The nature of the final adverse action and whether such action is on appeal.

(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the task force determines is required for appropriate interpretation of information reported under this section.

(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the

task force prescribes. Such information shall first be required to be reported on a date specified by the task force.

(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the task force.

(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the task force under this section respecting a health care provider, supplier, or practitioner, the task force shall provide for—

(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

(B) procedures in the case of disputed accuracy of the information.

(2) CORRECTIONS.—Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the task force prescribes.

(d) ACCESS TO REPORTED INFORMATION.—

(1) AVAILABILITY.—The information in this database shall be available to Federal and State government agencies and health plans pursuant to procedures that the task force shall provide.

(2) FEES FOR DISCLOSURE.—The task force may establish or approve reasonable fees for the disclosure of information in this database (other than with respect to requests by Federal agencies). The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the task force.

(e) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

(f) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

(1)(A) The term ''final adverse action'' includes:

(i) Civil judgments against a health care provider in Federal or State court related to the delivery of a health care item or service.

(ii) Federal or State criminal convictions related to the delivery of a health care item or service.

(iii) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

(I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation;

(II) any other loss of license of the provider, supplier, or practitioner, by operation of law; or

(III) any other negative action or finding by such Federal or State agency that is publicly available information.

(iv) Exclusion from participation in Federal and State health care programs.

(v) Any other adjudicated actions or decisions that the task force shall establish.

(B) The term does not include any action—

(i) with respect to a malpractice claim; or

(ii) which is based on something other than health care fraud and abuse.

(2) The terms ''licensed health care practitioner'', ''licensed practitioner'', and ''practitioner'' mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

(3) The term ''health care provider'' means a provider of services as defined in section 1861(u) of the Social Security Act, and any entity, including a health maintenance organization, group medical practice, or any other entity listed by the Secretary in regulation, that provides health care services.

(4) The term ''supplier'' means a supplier of health care items and services described in section 1819 (a) and (b), and section 1861 of the Social Security Act.

(5) The term ''Government agency'' shall include:

(A) The Department of Justice.

(B) The Department of Health and Human Services.

(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not

limited to the Department of Defense and the Veterans' Administration.

(D) State law enforcement agencies.

(E) State Medicaid fraud and abuse units.

(F) Federal or State agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

(G) The task force.

(6) The term ''health plan'' has the meaning given such term by section 101(c).

(7) For purposes of paragraph (2), the existence of a conviction shall be determined under paragraph (4) of section 1128(j) of the Social Security Act.

(g) CONFORMING AMENDMENT.—Section 1921(d) of the Social Security Act is amended by inserting ''and section 301 of the Health Care Anti-Fraud Act of 1995'' after ''section 422 of the Health Care Quality Improvement Act of 1986''.

TITLE IV—MONETARY PENALTIES

SEC. 401. SOCIAL SECURITY ACT CIVIL MONETARY PENALTIES.

(a) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) of the Social Se-

curity Act (42 U.S.C. 1320a–7a(a)) is amended in the matter following paragraph (3)—

(1) by striking ''$2,000'' and inserting ''$10,000'';

(2) by striking $15,000 and inserting $75,000; and

(3) by striking ''twice the amount'' and inserting ''3 times the amount''.

(b) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) of the Social Security Act (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) in subparagraph (A) by striking ''claimed,'' and inserting ''claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or has reason to know will result in a greater payment to the person than the code the person knows or has reason to know is applicable to the item or service actually provided,'';

(2) in subparagraph (C), by striking ''or'' at the end;

(3) in subparagraph (D), by striking ''; or'' and inserting '', or''; and

(4) by inserting after subparagraph (D) the following new subparagraph:

''(E) is for a medical or other item or service that a person knows or has reason to know is not medically necessary; or''.

(c) PERMITTNG SECRETARY TO IMPOSE CIVIL MONETARY PENALTY.—Section 1128A(b) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended by

(1) adding the following new paragraph:

''(3) Any person (including any organization, agency, or other entity, but excluding a beneficiary as defined in subsection (i)(5)) who the Secretary determines has violated section 1128B(b) of this title shall be subject to a civil monetary penalty of not more than $10,000 for each such violation. In addition, such person shall be subject to an assessment of not more than three times the total amount of the remuneration offered, paid, solicited, or received in violation of section 1128B(b). The total amount of remuneration subject to an assessment shall be calculated without regard to whether some portion thereof also may have been intended to serve a purpose other than one proscribed by section 1128B(b).'' and

(2) striking $2,000 each place it appears and inserting $10,000.

(d) SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.—Section 1156(b)(3) of the Social Security Act (42 U.S.C. 1320c–5(b)(3)) is amended by striking ''the actual or estimated cost'' and inserting ''up to $10,000 for each instance''.

(e) PROCEDURAL PROVISIONS.—Section 1876(i)(6) of the Social Security Act (42 U.S.C. m(i)(6)) is amended

(1) by adding at the end the following new subparagraph:

''(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (A) or (B) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).'',

(2) by striking $25,000 and inserting $125,000;

(3) by striking $100,000 and inserting $1,000,000; and

(4) by striking $15,000 and inserting $75,000.

(f) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(A) by striking ''or'' at the end of paragraph (1)(D);

(B) by striking '', or'' at the end of paragraph (2) and inserting a semicolon;

(C) by striking the semicolon at the end of paragraph (3) and inserting ''; or''; and

(D) by inserting after paragraph (3) the following new paragraph:

''(4) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program;''.

(2) REMUNERATION DEFINED.—Section 1128A(i) of such Act (42 U.S.C. 1320a–7a(i)) is amended by adding the following new paragraph:

''(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any

part thereof), and transfers of items or services for free or for other than fair market value. The term 'remuneration' does not include—

''(A) the waiver of coinsurance and deductible amounts by a person, if—

''(i) the waiver is not offered as part of any advertisement or solicitation;

''(ii) the person does not routinely waive coinsurance or deductible amounts; and

''(iii) the person—

''(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

''(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

''(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;

''(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been dis-

closed in writing to all beneficiaries, third party payors, and providers, to whom claims are presented; or

''(C) incentives given to individuals to promote the delivery of preventive care.

(g) CLARIFICATION OF INTENT STANDARD.—Section 1128A(i) of the Social Security Act (42 U.S.C. 1320a–7a(i)) is amended, by adding at the end the following new paragraph:

''(6) The term 'should know' means that a person, with respect to information—

''(A) acts in deliberate ignorance of the truth or falsity of the information; or

''(B) acts in reckless disregard of the truth or falsity of the information.''

(h) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1996.

SEC. 402. OTHER SOCIAL SECURITY ACT CIVIL PENALTIES.

(a) STANDARDS FOR NURSING FACILITIES.—

(1) PROVIDING ADVANCE NOTICE OF SURVEY TO NURSING FACILITY.—Section 1819(g)(2)(A)(i) of such Act (42 U.S.C. 1395i–3(g)(2)(A)(i)) is amended by striking ''$2,000'' and inserting ''$10,000''.

(b) DISTRIBUTION BY SUPPLIERS OF MEDICAL EQUIPMENT OF MEDICAL NECESSITY FORMS.—

(1) Section 1834(j)(2)(A)(iii) of such Act (42 U.S.C. 1395m(j)(2)(A)(iii)), as added by section 131(a)(1) of the Social Security Act Amendments of 1994, is amended by striking ''$1,000'' and inserting ''$5,000''; and

(2) Section 1834(j)(2)(B) of the Social Security Act is amended by inserting ''one-page'' before ''form''; and deleting ''or other document'' after ''form''.

(c) INTERMEDIATE SANCTIONS FOR PROVIDERS OR SUPPLIERS OF CLINICAL DIAGNOSTIC LABORATORY TESTS.—Section 1846(b)(2)(A)(ii) of such Act (42 U.S.C. 1395w–2(b)(2)(A)(ii)) is amended by striking ''$10,000'' and inserting ''$50,000''.

(d) MEDICARE SECONDARY PAYER.—

(1) OFFERING FINANCIAL INCENTIVES FOR BENEFICIARIES NOT TO ENROLL IN PRIMARY PLANS.—The second sentence of section 1862(b)(3)(C) of such Act (42 U.S.C. 1395y(b)(3)(C)) is amended by striking ''$5,000'' and inserting ''$25,000''.

(2) FAILURE OF EMPLOYER TO PROVIDE MATCHING INFORMATION ON SECONDARY PAYER SITUATIONS.—The second sentence of section 1862(b)(5)(C)(ii) of such Act (42 U.S.C.

1395y(b)(5)(C)(ii) is amended by striking ''$1,000'' and inserting ''$5,000''.

(3) FAILURE OF PROVIDER TO PROVIDE INFORMATION ON AVAILABILITY OF OTHER PAYERS.—Section 1862(b)(6)(B) of such Act (42 U.S.C. 1395y(b)(6)(B)), as added by section 151(a)(2)(A) of the Social Security Act Amendments of 1994, is amended by striking ''$2,000'' and inserting ''$10,000''.

(e) REFERRALS BY PHYSICIANS WITH OWNERSHIP OR INVESTMENT INTERESTS.—

(1) CIRCUMVENTION SCHEMES.—Section 1877(g)(4) of such Act (42 U.S.C. 1395nn(g)(4)) is amended by striking ''$100,000'' and inserting ''$500,000''.

(2) FAILURE TO REPORT INFORMATION.—Section 1877(g)(5) of such Act (42 U.S.C. 1395nn(g)(5)) is amended by striking ''$10,000'' and inserting ''$50,000''.

(f) MEDICARE SUPPLEMENTAL POLICIES.—

(1) ISSUANCE OF POLICIES WHERE NO STANDARDS IN EFFECT.—The second sentence of section 1882(a)(2) of such Act (42 U.S.C. 1395ss(a)(2)) is amended by striking ''$25,000'' and inserting ''$125,000''.

(2) MISREPRESENTATIONS OF POLICIES.—Section 1882(d) of such Act (42 U.S.C. 1395ss(d)) is amended—

(A) in paragraphs (1), (2), and (4)(A), by striking ''$5,000'' and inserting ''$25,000''; and

(B) in paragraphs (3)(A) and (3)(B)(iv), by striking ''$25,000 (or $15,000'' and inserting ''$125,000 (or $75,000''.

(3) VIOLATION OF BENEFITS STANDARDS.—Section 1882(p) of such Act (42 U.S.C. 1395ss(p)) is amended by striking ''$25,000 (or $15,000'' each place it appears in paragraphs (8) and (9)(C) and inserting ''$125,000 (or $75,000''.

(4) VIOLATION OF GUARANTEED RENEWABILITY STANDARDS.—Section 1882(q)(5)(C) of such Act (42 U.S.C. 1395ss(q)(5)(C)) is amended by striking ''$25,000'' and inserting ''$125,000''.

(5) VIOLATION OF LOSS RATIO STANDARDS.—Section 1882(r)(6)(A) of such Act (42 U.S.C. 1395ss(r)(6)(A)) is amended by striking ''$25,000'' and inserting ''$125,000''.

(6) VIOLATION OF PRE-EXISTING CONDITION STANDARDS.—Section 1882(s)(3) of such Act (42

U.S.C. 1395ss(s)(3)) is amended by striking ''$5,000'' and inserting ''$25,000''.

(7) MEDICARE SELECT POLICIES.—Section 1882(t)(2) of such Act (42 U.S.C. 1395ss(t)(2)) is amended by striking ''$25,000'' and inserting ''$125,000''.

(g) VIOLATION OF HOME HEALTH PARTICIPATION STANDARDS.—Section 1891 of such Act (42 U.S.C. 1395bbb) is amended—

(1) in subsection (a)(3)(D)(iii)(III), by striking ''$5,000'' and inserting ''$25,000'';

(2) in subsection (c)(1), by striking ''$2,000'' and inserting ''$10,000''; and

(3) in subsection (f)(2)(A)(i), by striking ''$10,000'' and inserting ''$50,000''.

SEC. 403. SOCIAL SECURITY ACT CRIMINAL PENALTIES.

(a) Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b) is amended—

(1) in subsection (a)—

(A) by striking ''$25,000'' and inserting ''$50,000'', and

(B) by striking ''$10,000'' and inserting ''$20,000'';

(2) in subsections (b), (c), and (d), by striking ''$25,000'' each place it appears and inserting ''$50,000''; and

(3) in subsection (e), by striking ''$2,000'' and inserting ''$4,000''.

TITLE V—AMENDMENTS TO ANTI-KICKBACK LAW

SEC. 501. CLARIFICATION OF STANDARDS.

(a) Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)) is amended by inserting, ''the substantial and primary purpose of which is,'' after ''in kind'' in paragraph (1) thereof, and after ''any person'' in paragraph (2) thereof.

(b) Section 1128A(i) of the Social Security Act (42 U.S.C. 1320a–7a(i)) is amended by adding at the end the following new paragraph:

''(6) The term ''should know'' means that a person, with respect to information—

''(A) acts in deliberate ignorance of the truth or falsity of the information; or

''(B) acts in reckless disregard of the truth or falsity of the information.''

SEC. 502. CLARIFICATIONS AND ADDITIONS TO ANTI-KICK-BACK EXCEPTIONS.

(a) EXCEPTION FOR DISCOUNTS.—Section 1128B(b)(3)(A) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)(A)) is amended by inserting the following: ''(including reductions in price applied to combinations of items and services, and reductions made available as part of capitation, risk sharing, disease management or similar programs)'' after ''a discount or other reduction in price''; and by inserting at the end: ''provided, however, that where an entity which does not report its costs on a cost report separately claims an item or service for payment, and payment by the Medicare program or a state health care program is not based on actual acquisition costs, then a price reduction on the item or service may be properly disclosed and appropriately reflected by providing full and accurate information concerning the price reduction at the time the value of the reduction is known, at the request of the Secretary or a State agency.''

(b) Section 1128B(b)(3) of the Social Security Act (42 U.S.C. § 1320a–7b(b)(3)) is amended as follows:

(1) In subparagraph (D), by striking ''Public Health Service Act; and'' and inserting ''Public Health Service Act;''

(2) By renumbering subparagraph (E) as subparagraph (K).

(c) EXCEPTION FOR MANAGED CARE RELATIONSHIPS.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3) is amended by inserting after subparagraph (D) the following:

''(E) any reduction in cost sharing or increased benefits given to an individual, any amounts paid to a provider for an item or service furnished to an individual, or any discount or reduction in price given by the provider for such item or service if the item or service is provided by an organization which—

''(i) provides health care services directly or through one or more subsidiary entities or arranges under agreement with contract health care providers for the provision of items or services, in exchange for a premium; and

''(ii) assumes or, in the case of items or services provided under agreement with contract health care providers, places the contract health care providers under, substantial financial risk (including through a withhold, capitation, incentive pool, per diem payment, or other similar substantial

risk-sharing arrangement) for the provision of health services.

For the purpose of this subparagraph, the term ''contract health care provider'' means an individual or entity under contract with a health plan to furnish items or services to enrollees who are covered by the health plan (which may include Title XVIII beneficiaries and Title XIX recipients).''.

(d) EXCEPTION FOR RISK-SHARING ARRANGEMENTS.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3) is amended—

(1) by redesignating subparagraph (E) as subparagraph (F);

(2) by striking ''and'' at the end of subparagraph (D); and

(3) by inserting after subparagraph (D) the following:

''(E) any remuneration between an organization and a provider of services pursuant to an agreement between the organization and provider if the written agreement places the provider of services at substantial financial risk for the cost or utilization of the services the provider is obligated to provide, whether through

capitation, incentive pools, per diem payments, or a similar risk-sharing arrangement that places the provider at substantial financial risk; and''.

(e) EXCEPTION FOR DE MINIMUS REMUNERATION.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended by inserting the following new subparagraph:

''(F) items provided free of charge to a licensed health care practitioner who is furnishing services reimbursed under title XVIII or a State health care program, provided the items primarily benefit patients receiving such services and the value of the items does not exceed limits set forth in generally accepted professional or ethical guidelines applicable to the health care practitioner (or, if no such guidelines exist, the value of the items does not exceed limits established by the Secretary);''.

(f) EXCEPTIONS FOR DRUG SAMPLES.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended by inserting the following new subparagraph:

''(G) drug samples distributed in compliance with section 503(d) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. § 553(d));''.

(g) EXCEPTION FOR SCIENTIFIC AND EDUCATIONAL PROGRAMS FOR PRACTITIONERS.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended by inserting the following new subparagraph:

''(H) any amount paid to support scientific or educational programs or materials for licensed health care practitioners or pharmacists, provided that—

''(i) such programs or materials are designed to improve the care or treatment of patients;

''(ii) such programs are conducted in accordance with generally accepted professional or ethical guidelines applicable to the health care practitioner; and

''(iii) the receipt of such amount, or of such programs or materials, is not conditioned on the purchase, lease, order, or furnishing (or the recommending for purchase, lease, order, or furnishing) of any item or service reimbursed under Title XVIII or a State health care program;''.

(h) EXCEPTION FOR EDUCATIONAL PROGRAMS FOR PATIENTS.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended by inserting the following new subparagraph:

''(I) any amount paid to provide educational programs or materials for patients, provided that—

''(i) the programs or materials are designed to improve the care, treatment (including compliance with treatment regimes), or health of such patients; and

''(ii) the receipt of such amount, or of such programs or materials, is not conditioned on the purchase, lease, order or furnishing (or the recommending of the purchase, lease, order, or furnishing) of any item or service reimbursed under Title XVIII or a State health care program;''.

(i) EXCEPTION FOR PAYMENTS MADE ON BEHALF OF HEALTH PLANS.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended by inserting the following new subparagraph:

''(J) any amount paid by a contract health plan service firm to a contract health provider, provided that the amount is paid at the direc-

tion of or on behalf of a health plan, and that the purpose of the payment is to reduce the cost or improve the quality of items or services provided by the health plan to its enrollees. For purposes of this subparagraph, the term—

''(i) 'contract health plan service firm' means an entity that is under a written agreement with a health plan to assist in carrying out the functions of the health plan;

''(ii) 'contract health provider' means an individual or entity that is under written agreement with a health plan to furnish to the health plan's enrollees items or services that are covered by the health plan, or reimburse under Title XVIII or a State health care plan; and

''(iii) 'health plan' means an entity that furnishes or arranges under agreement with contract health care providers for the furnishing of items or services to enrollees, or furnishes insurance coverage for the provision of such items and services, in exchange for a premium.''.

SEC. 503. CLARIFICATION OF SAFE HARBOR AUTHORITY IN ANTI-KICKBACK PROVISIONS.

Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)) is amended by adding at the end the following new paragraph:

''(4) The regulations authorized by section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 are—

''(A) solely for the purpose of adding additional exceptions to the conduct proscribed by this subsection, not for the purpose of limiting the scope of the exceptions specified in paragraph (3) of this subsection; and

''(B) for the purpose of prescribing criteria for qualifying for an exception notwithstanding the intent of the parties.''.

TITLE VI AMENDMENTS TO THE PHYSICIAN SELF-REFERRAL LAW

SEC. 601. FINANCIAL RELATIONSHIP DEFINED.

(a) Section 1877(a)(2) of the Social Security Act (42 U.S.C. 1395nn(a)(2)) is amended by deleting the paragraph heading ''(A)''; by deleting '',or'' at the end of paragraph (a) and by deleting, in its entirety, paragraph (B).

(b) Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) by deleting in its heading all language following ''EXCEPTIONS''.

(c) Section 1877(d) of the Social Security Act (42 U.S.C. 1395nn(d)) is amended in its title by deleting all language after ''EXCEPTIONS''.

(d) Section 1877(e) of the Social Security Act (42 U.S.C. 1395nn(e)) is deleted in its entirety.

(e) Section 1877(f) of the Social Security Act (42 U.S.C. 1395nn(f)) is amended by deleting '', and compensation'' after ''investment'' and paragraph (2) is amended by deleting '', or with a compensation arrangement (as described in subsection (a)(2)(B)) after ''investment interest'' and by deleting ''or who have such a compensation relationship with the entity'' after ''investment interest.''

(f) Section 1877(h) of the Social Security Act (42 U.S.C. 1395nn(h)) is amended by deleting paragraphs (1), (2), and (3).

SEC. 602. SELF-REFERRALS FOR PHYSICIAN SERVICES.

Section 1877(b)(1) of the Social Security Act (42 U.S.C. 1395nn(b)(1)) is amended by inserting ''the physician or'' immediately before ''another physician.''

SEC. 603. RISK-SHARING ARRANGEMENTS.

Section 1877(b)(3) of the Social Security Act (42 U.S.C. 1395nn(b)(3)) is amended as follows:

(1) By deleting from the heading the phrase ''Prepaid Plans'' and inserting in its place ''Risk-Sharing Arrangements''.

(2) By deleting from the heading the word ''by'' and inserting in its place ''to an individual enrolled with''; and

(3) By adding after subparagraph (3)(D) the following new subparagraph:

''(E) pursuant to written agreement between the organization and the provider of services if the written agreement places the provider of services at substantial financial risk (full or partial) for the cost or utilization of the services the provider is obligated to provide, whether through capitation, incentive pools, per diem payment arrangements, or other substantial financial risk-sharing arrangements.''.

SEC. 604. PHYSICIAN OWNERSHIP.

Section 1877(d) of the Social Security Act (42 U.S.C. 1395nn(d)) is amended by inserting at the end the following new paragraph:

''(4) INTEGRATED DELIVERY SYSTEM OWNERSHIP.—In the case of the physician's ownership or investment interest in a management services organization (MSO), preferred provider organization

(PPO), physician-hospital organization (PHO), physician-hospital arrangement (PHA), or similar organization designed to facilitate the integrated delivery of health care services, if the referring physician is managed by or contracts with the MSO, PPO, PHO, PHA or similar organization (or the group practice of which the physician is a member is managed by or contracts with the MSO, PPO, PHO, PHA or similar organization and the ownership or investment interest is in the MSO, PPO, PHA or similar organization itself (and not merely in a subdivision thereof).''.

SEC. 605. SHARED FACILITY SERVICES.

Section 1877(b) of such Act (42 U.S.C. 1395nn(b)) is amended—

(1) by redesignating paragraph (4) as paragraph (6); and

(2) by inserting after paragraph (3) the following new paragraph:

''(4) SHARED FACILITY SERVICES.—

''(A) IN GENERAL.—In the case of a shared facility services of a shared facility

''(i) that is furnished

''(I) personally by the referring physician who is a shared facility phy-

sician by an individual directly employed or directly supervised by such a physician,

''(II) by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician that are unrelated to the furnishing of shared facility services, and

''(III) to a patient of a shared facility physician; and

''(ii) that is billed by the referring physician.

''(B) SHARED FACILITY RELATED DEFINITIONS.—

(i) SHARED FACILITY SERVICE.—The term ''shared facility service'' means, with respect to a shared facility, a designated health service furnished by the facility to patients of shared facility physicians.

(ii) SHARED FACILITY.—The term ''shared facility'' means an entity that furnishes shared facility services under a shared facility arrangement.

(iii) SHARED FACILITY PHYSICIAN.—The term ''shared facility, a physician who has a financial relationship under a shared facility arrangement with the facility.

(iv) SHARED FACILITY ARRANGEMENT.—The term ''shared facility arrangement'' means, with respect to the provision of shared facility services in a building, a financial arrangement.

(I) which is only between physicians who are providing services (unrelated to shared facility services) in the same building;

(II) in which the overhead expenses of the facility are shared, in accordance with methods previously determined by the physicians in the arrangement; and

(III) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.''.

SEC. 606. PAYER DIRECTED CARE.

(a) Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is amended by inserting the following

paragraph after paragraph 4, as amended by section 604 of the Health Care Anti-Fraud Act of 1995:

''(5) PAYER DIRECTED CARE.—In the case of items or services furnished to a patient where the selection of provider is substantially determined by, or results from financial incentives provided by, a payer of such items or services.''.

SEC. 607. SELF-REFERRALS FOR CERTAIN DESIGNATED HEALTH SERVICES.

(a) Section 1877(h)(6) of the Social Security Act (42 U.S.C. n(h)(6)) is amended by deleting paragraph (k) thereof.

SEC. 608. DEFINITION OF DIRECT SUPERVISION.

(a) Section 1877(h) of the Social Security Act (42 U.S.C. n(h)) is amended by adding at the end thereof the following new paragraph:

''(7) 'Directly supervised' by a physician means the physician has responsibility for oversight of the provision, by a person (whether or not an employee of the physician or group practice), of in-office ancillary services, and such responsibility must include:

''(A) Specifying the tasks to be performed by the person;

''(B) Instructing the person with regard to the manner and method for performing the tasks;

''(C) Evaluating the person's performance of the tasks;

''(D) Taking, or causing to be taken, personnel actions which are based upon evaluation of the person's performance of the tasks; and

''(E) Being available, in person or by telephone, to the person at all times such person is providing in-office ancillary services.''.

SEC. 609. EFFECTIVE DATE.

(a) Section 1877 of the Social Security Act (42 U.S.C. n(h)) is amended with respect to its effective date as follows:

''In the case of designated health services other than clinical laboratory services, this law shall apply to referrals made after the later of:

''(1) December 31, 1994; or

''(2) the date that final regulations implementing all sections of this law are promulgated.''.

TITLE VII—MEDICARE BILLING ABUSE PREVENTION

SEC. 701. IMPLEMENTATION OF GENERAL ACCOUNTING OFFICE RECOMMENDATIONS REGARDING MEDICARE CLAIMS PROCESSING.

(a) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary shall, by regulation, contract, change order, or otherwise, require Medicare carriers to acquire commercial automatic data processing equipment (in this title referred to as ''ADPE'') meeting the requirements of section 702 to process Medicare part B claims for the purpose of identifying intentional billing code abuse.

(b) SUPPLEMENTATION.—Any ADPE acquired in accordance with subsection (a) shall be used as a supplement to any other ADPE used in claims processing by Medicare carriers.

(c) STANDARDIZATION.—In order to ensure uniformity, the Secretary may require that Medicare carriers that use a common claims processing system acquire common ADPE in implementing subsection (a).

(d) IMPLEMENTATION DATE.—Any ADPE acquired in accordance with subsection (a) shall be in use by Medicare carriers not later than one year after the date of the enactment of this Act.

SEC. 702. MINIMUM SOFTWARE REQUIREMENTS.

(a) IN GENERAL.—The requirements described in this section are as follows:

(1) The ADPE shall be a commercial item and shall be reviewed by a private standard setting organization with expertise in the development of descriptive terms and identifying codes for reporting medical services and procedures. The Secretary shall determine the appropriate organization to perform this review.

(2) The ADPE shall surpass the capability of ADPE used in the processing of Medicare part B claims for identification of code manipulation on the day before the date of the enactment of this Act.

(3) The ADPE shall be capable of being modified to—

(A) satisfy pertinent statutory requirements of the Medicare program; and

(B) conform to general policies of the Health Care Financing Administration regarding claims processing.

(b) MINIMUM STANDARDS.—Nothing in this title shall be construed as preventing the use of ADPE which exceeds the minimum requirements described in subsection (a).

SEC. 703. DISCLOSURE.

(a) IN GENERAL.—Notwithstanding any other provision of law, and except as provided in subsection (b), any ADPE or date related thereto acquired by Medicare carriers in accordance with section 701(a) shall not be subject to public disclosure.

(b) EXCEPTION.—The Secretary may authorize the public disclosure of any ADPE or data related thereto acquired by Medicare carriers in accordance with section 701(a) if the Secretary determines that—

(1) release of such information is in the public interest; and

(2) the information to be released is not protected from disclosure under section 552(b) of title 5, United States Code.

(c) COPYRIGHT PROTECTION.—Nothing in this part, or any other part, shall be construed to divest the holder of a copyright in any code set, of its copyright in such code set or in any derivative work made therefrom.

SEC. 704. REVIEW AND MODIFICATION OF REGULATIONS.

Not later than 30 days after the date of the enactment of this Act, the Secretary shall order a review of existing regulations, guidelines, and other guidance governing Medicare payment policies and billing code abuse to determine if revision of or addition to those regulations, guidelines, or guidance is necessary to maximize the bene-

fits to the Federal Government of the use of ADPE acquired pursuant to section 701.

SEC. 705. DEFINITIONS.

For purposes of this title—

(1) The term ''automatic data processing equipment'' (ADPE) has the same meaning as in section 111(a)(2) of the Federal Property and Medicare payments for Medicare part B benefits payable on a charge basis and to perform other related functions.

(2) The term ''billing code abuse'' means the intentional and willful submission to Medicare carriers of claims for services that include procedure codes that do not appropriately describe the total services provided or otherwise violate Medicare payment policies.

(3) The term ''commercial item'' has the same meaning as in section 4(12) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(12)).

(4) The term ''Medicare part B'' means the supplementary medical insurance program authorized under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j–1395w–4).

(5) The term ''Medicare carrier'' means an entity that has a contract with the Health Care Financing Administration to determine and make Med-

icare payments for Medicare part B benefits payable on a charge basis and to perform other related functions.

(6) The term ''payment policies'' means regulations and other rules that govern billing code abuses such as unbundling, global service violations, double billing, and unnecessary use of assistants at surgery.

(7) The term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 706. TERMINATION OF PROPOSED MEDICARE TRANSACTION SYSTEM.

The Secretary may not implement the Medicare transaction system proposed to detect improper billing for items and services under the Medicare program resulting from the improper unbundling of items and services.

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